



HEALTH POLICIES

OVERVIEW OF POLICY - The school nurse maintains medical records for every child and requests parental help in keeping these records up to date. If your child has a persistent condition, allergies or any medical condition that the school should be aware of, please specify in detail the nature of the condition, the signs and symptoms and any medication that may need to be administered immediately.

MEDICAL CHECK-UP - The DHA requires that students in grades: KG1, 1, 5, 9, 12 and all-new students have a general medical examination. Body Mass Index (BMI) is checked for all students annually. Parents will be informed if their child requires any special medical attention.

POLICY ON MEDICATION - If your child needs to take any medication during school hours, please ensure that this medication is stored in the School Clinic with the nurse. Medication will not be dispensed without a parental written permission and detailed doctor's prescription including dosage and frequency.

POLICY ON IMMUNISATION - RWA provides immunization for students under the Umbrella of Dubai Health Authorities (DHA). Nurses from DHA will be conducting the vaccination program at RWA. If you agree on your child receiving vaccination at school, please provide the original vaccination record.

All parents are asked to submit a recent copy of their child's vaccination records during admission.

POLICY ON ACCIDENTS AND EMERGENCIES – School Nurse or School personnel shall notify the parents or guardians in the event of accidents or cases of emergencies.

POLICY ON INFECTIOUS DISEASES - Children should not be sent to school if they are unwell. In the case of infectious diseases such as Chicken Pox, Conjunctivitis, Mumps etc., they should only return to school when the quarantine period ceases. No child will be allowed to attend school without a medical certificate or the school doctor's approval in the case of having contracted any infectious disease.

HEAD LICE - Parents are asked to regularly check their children's hair for nits and lice. A check-up will be done if a case of head lice is reported in any particular class and a letter sent to the parents. Student is allowed back to class only if cleared by School Doctor. Head Lice is a common condition amongst children, and can be easily treated.

MEDICAL DECLARATION – Please complete all the medical forms, answer all the questions clearly and return it to the clinic/admission office as soon as possible.

Contacting the School Clinic

Clinic Mobile No. - **055-964-4812**

Telephone: Doctor - **04-4271349** E- mail: vaneetaa@rwadubai.com

Telephone: Nurse - **04-4271350** E- mail: nerissau@rwadubai.com, jembya@rwadubai.com

Photo

Dear Parent or Guardian of the Student:

Please fill the attached form accurately in order to protect your son or daughter's health.

If the answer is yes, please write the date and details in comments cell. Accuracy is needed for us to be able to follow their health status.

Best wishes for good health and wellness

School Information

School Name: Grade: Class:

Student Information

Student Full Name: Gender:

Date of Birth: Nationality:

Parent or Legal Guardian Name: Relationship:

Mobile Phone Number (1): Mobile Phone Number (2):

E-Mail: Emirate:

In case of Emergency and not being able to reach parents, the following person can be contacted:

Name: Relationship: Mobile Phone Number:

Required Attachments

Student Emirates ID	<input type="checkbox"/> Yes	<input type="checkbox"/> No	ID Number:
Student Passport Copy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Original Vaccination Card	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Health Card Number (if any)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Health Card Number:
Health Insurance Card (if any)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Health Insurance Card Number:

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Medical History of the student

Is there any health problem, out of the following? If the answer is yes, please state the problem type and date in comments cell

Health Problem		Yes	No	Comments
1	Any allergy to drug, food, dust			
2	Cardiovascular problem			
3	Diabetes			
4	Hypertension			
5	Asthma			
6	Renal Problem			
7	Epilepsy seizures or Convulsion seizures			
8	Epistaxis			
9	Hemolytic Anemia, type G6PD			
10	Hereditary Blood Disease (e. g. Thalassemia, sickle cell anemia, Hemophilia), Please specify if any			
11	Skin Problem			
12	Eye problem (Myopia, Hyperopia,), Please specify if any			
13	Hearing problem			
14	Any case that may weaken Immunity System such as Cancer (Blood cancer, Lymphoma), or transplantation, Please specify if any			
15	One of the following diseases: (Mumps, Measles, Diphtheria, Pertussis, Chickenpox, Tuberculosis), Please specify if any			
16	Viral Hepatitis			
17	Poliomyelitis (Infantile paralysis infection)			
18	Mental or Behavioral Problem, Please specify if any			
19	Any other Problem or disease not mentioned here, Please specify if any			
20	Is there a previous exposure to any accident?			
21	Is there any previous hospitalization? Please mention the cause if any			
22	Is there any previous exposure to surgery? Please mention the cause if any			
23	Is there any previous blood, antibodies or plasma transfusion?			
24	Was there a need to use any medical aid device? Please specify if any			

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If the student suffer from one of the health problems mentioned or not mentioned above, please answer the following questions

Drugs or Treatments taken continuously

Drug Name: Dosage:

Emergency Drugs

Drug Name: Dosage:

Specific Instructions of the treating doctor regarding Nutrition

Specific Instructions of the treating doctor regarding exercise and physical activity

Specific Instructions of the treating doctor to school nurse to be applied during the school day

Family Health History

	Health Problem	Yes	No	Comments
1	Hypertension			
2	Diabetes			
3	Tuberculosis			
4	Mental disorder			
5	Stroke			
6	Others, specify			

Parent or Guardian approval and verification for the above mentioned information

Name of Parent or Legal Guardian:

Relationship.....

Signature of the parent or legal Guardian:

Date:

Notes

The parent of legal guardian of the student should fill this form. He or she is responsible for the abovementioned information.

Medical report about the health problem should be attached.

Parents and Legal Guardians are responsible for informing school nurse about any change that occur in health status of the student. They should provide the school nurse with the required reports needed to be added the student health file.

Please contact school nurse or doctor if there is any queries.

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CONSENT FOR EMERGENCY TREATMENT

In the event that my child requires emergency treatment, I will be contacted and asked to collect my child from the school.

If the school is unable to contact me or the Emergency Contact Person, my child will be taken to Rashid Hospital (Dubai Government Hospital) accompanied by the School Nurse, for diagnosis and treatment. Efforts to contact me will continue.

I consent to my child being taken to Rashid Hospital in the event of a medical emergency.

Name of Parent: ----- Signature: ----- Date: -----

RAFFLES WORLD ACADEMY INFECTION CONTROL POLICY

In order to reduce and minimize the spread of illnesses in the school, the following regulations shall apply.

1. Please do not send your child to school if they have:
 - Fever
 - Skin rash
 - Vomiting (not to return to School for 24 hours after the last vomiting episode)
 - Diarrhoea (not to return to School for 24 hours after the last diarrhoea episode)
 - Persistent cough
 - Heavy nasal discharge
 - Red, watery and painful eyes
2. An infected sore or wound must be covered by a well-sealed dressing or plaster.
3. If your child is assessed by the School Doctor and/or School Nurse, and deemed to be a possible source of infection to other students, you will be contacted to take the child home immediately.

Please inform the school if your child has been or is being treated for a medical condition.

I have read and understand the above Infection Control Policy.

Name of Parent: ----- Signature: ----- Date: -----

CONSENT FOR MEDICAL EXAMINATION BY SCHOOL DOCTOR / NURSE YES NO

Name of Parent: ----- Signature: ----- Date: -----

Previous school in Dubai(if one attended)

: _____

CONSENT FOR MEDICINES ADMINISTRATION

Student's Name ----- Grade ----- Section -----

I consent / do not consent to my child being given any of the following medicines, should it be considered necessary by the school doctor or nurse.

If your child is unable to take this medication, please contact the school doctor or school nurse to discuss the use of an alternative medication.

The medical staff will contact you if there are any concerns.

Name of drug	Age	Dose	Indication	Remarks
Panadol Syrup	1-5 years 5-12 years	10-15mg/kg/	Fever, Pain	Every 4 - 6 hours
Panadol Tab (500mg)	and above	1-2 tablets	Fever, Pain	Repeat after 4 - 6 hours
Brufen Syrup	5-12 years	5-7.5 ml	Pain, Fever	As needed, Every 6 hrs History of allergy should be noted.
Brufen Tab	>12 yrs	tab	Pain, Fever	As needed, Every 6 hrs History of allergy should be noted.
Claritin, /Zyrtec Syrup	5-12 years	-5 ml	Allergy, insect bite	As needed, Every 24 hrs
Claritinel/Zyrtec Tab	>12 years	tab	Allergy, insect bite	As needed, Every 24 hrs
Maalox Plus Syrup	2-5 years; 5ml 6-18 years; 5-10ml	-	Nausea, Indigestion	Repeated after 2 hours
Scopinal syrup/tab	6-18 years	5-10 ml tab	Abdominal pain	Repeat after 6 hours
Fenistil Gel	All	-	Allergy, Insect bite	Every 8 hours
Medigel	All	Apply on affected area	Mouth ulcers	As needed
Reparil Gel / Voltaren Gel	All	Apply on affected area	Muscular trauma/swelling	As needed
Arnica Gel	All	Apply on affected area	Bruises	As needed

Name of Parent: ----- Signature: ----- Date: -----

CONSENT FOR VACCINATION IN SCHOOL PROGRAM

YES

NO

Name of Parent: ----- Signature: ----- Date: -----

IF NO, (you do not consent for vaccination in school) please fill-up the below refusal form.



Letter for refused vaccination in the school premises

Student Name:

Date of Birth:

Class/Grade:

School Name:

I am Mr. / Mrs. (Father/Mother) of Student.....

This is to inform you that I have objection for my son/daughter to receive the vaccination in the school premises for the reason of

I agree & assure to provide the school with a copy of updated vaccination record in regular basis.

Signature:

Date:

Telephone Number: